ElAHealth/Small Group Program
ASO PPO 80/50 Silver
Benefit Summary
(Uniform Health Plan Benefits and Coverage Matrix)

THIS MATRIX IS INTENDED TO BE USED TO HELP YOU COMPARE COVERAGE BENEFITS AND IS A SUMMARY ONLY. THE PLAN CONTRACT SHOULD BE CONSULTED FOR A DETAILED DESCRIPTION OF COVERAGE BENEFITS AND LIMITATIONS.

Blue Shield of California

Effective: January 1, 2015

	Preferred Providers[1]	Non-Preferred Providers[1]
Calendar Year Medical Deductible (All providers combined; 4th quarter carryover applies)	$2,000 per individual / $4,000 per family	
Calendar Year Out-of-Pocket Maximum (Copayments for Preferred Providers accrue to both Preferred and Non-Preferred Provider Calendar-year Out-of-Pocket Maximum amounts.)	$5,000 per individual / $10,000 Per family	
LIFETIME BENEFIT MAXIMUM	None	

Covered Services	**Member Copayment**	
PROFESSIONAL SERVICES	**Preferred Providers[1]**	**Non-Preferred Providers[1]**
Professional (Physician) Benefits		
• Physician and specialist office visits	$30 per visit (Not subject to the Calendar-Year Deductible)	50%
• CT scans, MRIs, MRAs, PET scans, and cardiac diagnostic procedures utilizing nuclear medicine[3] (prior authorization is required)	20%	50%
• Other outpatient X-ray, pathology and laboratory (Diagnostic testing by providers other than outpatient laboratory, pathology, and imaging departments of hospitals/facilities)[3]	No Charge (Not subject to the Calendar-Year Deductible)	50%
Allergy Testing and Treatment Benefits		
• Office visits (includes visits for allergy serum injections)	20%	50%
Preventive Health Benefits		
• Preventive Health Services (As required by applicable to federal law.)	No Charge (Not subject to the Calendar-Year Deductible)	Not Covered
OUTPATIENT SERVICES		
Hospital Benefits (Facility Services)		
• Outpatient surgery performed at an Ambulatory Surgery Center[4]	20%	50%[5]
• Outpatient surgery in a hospital	20%	50%[5]
• Outpatient Services for treatment of illness or injury and necessary supplies (Except as described under "Rehabilitation Benefits")	20%	50%[5]
• CT scans, MRIs, MRAs, PET scans, and cardiac diagnostic procedures utilizing nuclear medicine performed in a hospital (prior authorization is required)[3]	$100 per visit + 20%	50%[5]
• Other outpatient X-ray, pathology and laboratory performed in a hospital[3]	$25 per visit + 20%	50%[5]
• Bariatric Surgery (prior authorization required by the Plan; medically necessary surgery for weight loss, for morbid obesity only)[6]	20%	50%[5]
HOSPITALIZATION SERVICES		
Hospital Benefits (Facility Services)		
• Inpatient Physician Services	20%	50%
• Inpatient Non-emergency Facility Services (Semi-private room and board, and medically-necessary Services and supplies, including Subacute Care)	20%	50%[7]
• Bariatric Surgery (prior authorization required by the Plan; medically necessary surgery for weight loss, for morbid obesity only)[6]	20%	50%[7]
Skilled Nursing Facility Benefits[8] (Combined maximum of up to 100 prior authorized days per Calendar Year; semi-private accommodations)		
• Services by a free-standing Skilled Nursing Facility	20%	20%[7,9]
• Skilled Nursing Unit of a Hospital	20%	50%[7]

EMERGENCY HEALTH COVERAGE		
• Emergency room Services not resulting in admission (Copayment does not apply if the member is directly admitted to the hospital for inpatient services)	$100 per visit + 20%	$100 per visit + 20%
• Emergency room Services resulting in admission (when the member is admitted directly from the ER)	20%	20%
• Emergency room Physician Services	20%	20%
AMBULANCE SERVICES		
• Emergency or authorized transport	20%	20%
PROSTHETICS/ORTHOTICS		
• Prosthetic equipment and devices (Separate office visit copay may apply)	20%	50%
• Orthotic equipment and devices (Separate office visit copay may apply)	20%	50%
DURABLE MEDICAL EQUIPMENT		
• Breast pump	No Charge (Not subject to the Calendar-Year Deductible)	Not Covered
• Other Durable Medical Equipment	20%	50%
MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES[10, 11]		
• Inpatient Hospital Services	20%	50%[7]
• Residential Care	20%	50%[7]
• Outpatient Mental Health and Substance Abuse Services	$30 per visit (Not subject to the Calendar-Year Deductible)	50%
HOME HEALTH SERVICES[12]		
• Home health care agency Services[8] (up to 100 prior authorized visits per Calendar Year)	20%	Not Covered[12]
• Home infusion/home intravenous injectable therapy and infusion nursing visits provided by a Home Infusion Agency	20%	Not Covered[12]
OTHER		
Hospice Program Benefits[12]		
• Routine home care	20%	Not Covered[12]
• Inpatient Respite Care	20%	Not Covered[12]
• 24-hour Continuous Home Care	20%	Not Covered[12]
• General Inpatient care	20%	Not Covered[12]
Chiropractic Benefits[8]		
• Chiropractic Services - (provided by a chiropractor) (up to 26 visits per Calendar Year, combined with Acupuncture benefits)	20% (Plan payment maximum of $50 per visit)	50% (Plan payment maximum of $25 per visit)
Acupuncture Benefits[8]		
• Acupuncture (up to 26 visits per calendar, year combined with Chiropractic services)	20%	20%
Rehabilitation Benefits (Physical, Occupational and Respiratory Therapy)		
• Office location	20%	50%
Speech Therapy Benefits		
• Office Visit - Services by licensed speech therapists	20%	50%
Pregnancy and Maternity Care Benefits		
• Prenatal and postnatal Physician office visits (For inpatient hospital services, see "Hospitalization Services.")	20%	50%
• Abortion Services[13]	20%	Not Covered
Family Planning Benefits		
• Counseling and Consulting[2]	No Charge (Not subject to the Calendar-Year Deductible)	Not Covered
• Tubal ligation	No Charge (Not subject to the Calendar-Year Deductible)	Not Covered
• Vasectomy[13]	20%	Not Covered
Diabetes Care Benefits		
• Devices, equipment, and non-testing supplies	20%	50%
• Diabetes self-management training (If billed by your provider, you will also be responsible for the office visit copayment)	$30 per visit	50%
Care Outside of Plan Service Area (Benefits provided through the BlueCard®		

Program for out-of-state emergency and non-emergency care are provided at the preferred level of the local Blue Plan allowable amount when you use a Blue Cross/Blue Shield provider)		
• Within US: BlueCard Program	See Applicable Benefit	See Applicable Benefit
• Outside of US: BlueCard Worldwide	See Applicable Benefit	See Applicable Benefit

1 Member is responsible for copayment in addition to any charges above allowable amounts. The copayment percentage indicated is a percentage of allowable amounts. Preferred providers accept Blue Shield's allowable amount as full payment for covered services. Non-preferred providers can charge more than these amounts. When members use non-preferred providers, they must pay the applicable copayment plus any amount that exceeds Blue Shield's allowable amount. Charges above the allowable amount do not count toward the calendar-year deductible or Out-of-Pocket Maximum.

2 Includes insertion of IUD as well as injectable contraceptives for women.

3 Participating non Hospital based ("freestanding") outpatient X-ray, pathology and laboratory facilities centers may not be available in all areas. Regardless of their availability, you can obtain outpatient X-ray, pathology and laboratory services from a hospital or an ambulatory surgery center affiliated with a hospital, with payment according to your health plan's hospital services benefits.

4 Participating ambulatory surgery facilities centers may not be available in all areas. Regardless of their availability, you can obtain outpatient surgery services from a hospital or an ambulatory surgery center affiliated with a hospital; with payment according to your health plan's hospital services benefits.

5 The maximum allowed charges for non-emergency surgery and services performed in a non-participating Ambulatory Surgery Center or outpatient unit of a non-preferred hospital is $350 per day. Members are responsible for 50% of this $350 per day, plus all charges in excess of $350.

6 Bariatric surgery is covered when pre-authorized by the Plan. However, for members residing in Imperial, Kern, Los Angeles, Orange, Riverside, San Bernardino, San Diego, Santa Barbara and Ventura Counties ("Designated Counties"), bariatric surgery services are covered only when performed at designated contracting bariatric surgery facilities and by designated contracting surgeons; coverage is not available for bariatric services from any other preferred provider and there is no coverage for bariatric services from non-preferred providers. In addition, if prior authorized by the Plan, a member in a Designated County who is required to travel more than 50 miles to a designated bariatric surgery facility will be eligible for limited reimbursement for specified travel expenses for the member and one companion. Refer to the Plan Contract for further benefit details.

7 The maximum allowed charges for non-emergency hospital services received from a non-preferred hospital is $600 per day. Members are responsible for 50% of this $600 per day, plus all charges in excess of $600.

8 For plans with a calendar-year medical deductible amount, services with a day or visit limit accrue to the calendar-year day or visit limit maximum regardless of whether the plan medical deductible has been met.

9 Services may require prior authorization by the Plan. When services are prior authorized, members pay the preferred or participating provider amount.

10 Mental health and substance abuse services are accessed through Blue Shield's using Blue Shield's participating and non-participating providers.

11 Inpatient services for acute detoxification are covered under the medical benefit; see hospitalization services for benefit details. Services for medical acute detoxification are accessed through Blue Shield using Blue Shield's preferred providers or non-preferred providers.

12 Out of network home health care, home infusion and hospice services are not covered unless pre-authorized. When these services are pre-authorized, the member pays the Preferred Provider copayment.

13 Copayment shown is for physician's services. If the procedure is performed in a facility setting (hospital or outpatient surgery center), an additional facility copayment may apply. Services from non-participating providers and non-preferred facilities are not covered under this benefit.

Plan designs may be modified to ensure compliance with federal requirements.

Small Group Silver PPO Plan

EXPRESS SCRIPTS®

	Home Delivery	Retail (in network)
Generics	$20.00	$10.00
Preferred brands	$40.00	$20.00
Nonpreferred brands (no	$90.00	$45.00
Nonpreferred brands	$90.00	$45.00
Specialty Drugs	30% with a $300 copay maximum	30% with a $150 copay maximum
Deductible (Individual /	$200 / $500; applies to brand name drugs only	
Out of Pocket Maximum	$1,600 / $3,200	

SAVING WITH HOME DELIVERY

When you get maintenance medications (those prescription drugs you take regularly) at a retail pharmacy, you could be paying more than you need to. Use Express Scripts home delivery pharmacy services* for drugs to treat an ongoing condition (3 months or longer). We will deliver up to a 90-day supply right to you with free standard shipping.

RETAIL REFILL ALLOWANCE

The first three times that you purchase a long-term drug at a participating retail pharmacy, you'll pay your retail co-payment. After the third purchase, you'll pay a higher cost if you continue to purchase at retail. To avoid paying more, use the Express Scripts pharmacy and pay your mail-order co-payment for up to a 90-day supply. That means you'll pay less over time. Your medications will be delivered right to you, and standard shipping is free. Once you get started, you can request refills easily by mail, online or over the phone.

SAVING WITH GENERICS

FDA-approved generics are as safe and effective as their brand-name counterparts. If you're taking a brand-name drug, talk to your doctor and ask whether a less expensive generic drug could treat your condition. If your doctor agrees, ask your doctor to write a new prescription for the generic that you can fill through your prescription benefit.

*If you purchase a brand-name medication when a generic medication is available, you will pay the generic copayment, plus the difference in cost between the brand and the generic.

Home delivery... it's quick and easy

» Call us

We'll contact your doctor to get a new 90-day prescription for home delivery.

or

» Talk to your doctor

Ask your doctor for a new prescription for up to a 90-day supply. Have your doctor call us at 1.888-327-9791 **for instructions on how to fax your prescription**

Manage your prescriptions online and on the go	Register on Express-Scripts.com	Download the Express Scripts mobile app
Receive prescription reminders	√	√
Search for potential lower-cost options using **My Rx Choices**®	√	√
Receive prescription and drug interaction alerts	√	√
Show your virtual ID card at the retail pharmacy		√
Contact a pharmacist	√	
Check your coverage, claims and balances	√	
Print claim forms, order forms and fax forms	√	

*Includes services provided by the Express Scripts Pharmacy.SM